STATE OF NEW HAMPSHIRE

DEPARTMENT OF SAFETY
Division of Motor Vehicles
Stephen E Merrill Building
23 Hazen Drive Concord, NH 03305
TDD Access: Relay NH 1-800-735-2964

APPLICATION FOR WAIVER OF PHYSICAL DEFICIENCY

RSA 266:72-a, III, authorizes the commissioner to waive specific requirements or standards of the medical examination for drivers of all vehicles subject to the motor carrier safety rules who operate exclusively in intrastate commerce and do not carry hazardous materials, if it would not jeopardize the public safety. The specific requirements and standards for the medical examinations are contained in Title 49 of the Code of Federal Regulations part 391.43

Additional copies of this application may be obtained by written request to:

NH Department of Safety
Division of Motor Vehicles – Director's Office
23 Hazen Drive
Concord, New Hampshire 03305
or by calling: (603) 227-4050

TECHNICAL ASSISTANCE

Please read the entire application thoroughly before filling it out. Technical assistance is available if you need help completing this application. For technical assistance, please contact the Division of Motor Vehicles (603) 227-4050.

DUTIES

The waiver of Physical Deficiency shall authorize the driver-applicant to operate only the type of motor vehicle(s) defined in the waiver when the driver-applicant is in compliance with all the conditions and limitations of the waiver or legible copy in their possession whenever on duty.

TERMS AND LIMITATIONS

A Waiver of Physical Deficiency shall be valid for a period not to exceed two (2) years from date issued and the renewal process may be initiated sixty (60) days prior to the expiration date.

FALSE INFORMATION

Falsifying information in this application by either the driver-applicant or the motor carrier shall be just cause to deny the granting of a waiver and shall also be just cause to revoke a waiver (RSA 641:3).

INSTRUCTIONS

THIS APPLICATION SHALL BE ACCOMPANIED BY THE FOLLOWING:

A copy of the results of the medical examination performed (pursuant to 49 CFR 391.43).

A copy of the medical certificate completed (pursuant to 49 CFR 391.43 (f)).

.A medical evaluation summary completed by a licensed physician. The driver-applicant shall provide the physician with a description of the job tasks they will be required to perform.

The summary shall include an assessment of the driver's functional capabilities as they relate to their ability to perform normal tasks associated with operating a commercial motor vehicle; or

An explanation as to whether the impairment interferes with the driver's ability to perform normal tasks associated with operating a commercial motor vehicle. The summary shall also contain an assessment of whether the condition will likely remain medically stable over the driver-applicant's lifetime.

A description of the driver-applicant's prosthetic or orthotic device, if any and a statement regarding whether the driver-applicant is capable of demonstrating their ability to operate a commercial motor vehicle.

The driver-applicant shall be responsible for submitting a completed copy of the employment application from the last commercial driving position they held pursuant to 49 CFR 391.21). If not previously employed as a commercial driver, so state.

A copy of the driver-applicant's certified State Motor Vehicle record for the past three (3) years from each state in which a driver license or permit has been obtained, any at fault accident report records on file for the past ten (10) years (Saf-C 909-09(a)(3)).

AFTER COMPLETING THE APPLICATION:

Recheck the application for completeness
Be sure to enclose or attach all applicable supporting documentation to:

Department of Safety
Division of Motor Vehicles
Steven E. Merrill Building
23 Hazen Drive
Concord NH 03305

DRIVER-APPLICANT - GENERAL INFORMATION

CHECK ONE: New Applicant ☐ Renewal ☐

Last Name: _____ First Name: _____ MI:__

Date of Birth: __/__/____ Home Phone: ( ) ____-_____ Work Phone: ( ) ____-_____

Street Address _____

City/Town: _____State:_____ Zip Code: _____

Type of Driver License (example: operator, or CDL- A, B, C): _____ State_____

EMPLOYER/MOTOR CARRIER - GENERAL INFORMATION

Name of Employer/Motor Carrier: _____Contact Person:

_____

Phone: ( ) _____-_____ Street Address:_____

City: _____ State: _____ Zip Code: _____

REQUIRED INFORMATION

Description of driver-applicant's physical deficiency for which the waiver is requested:

_____

Date of deficiency: ____/___/_____

Description of the type of operation the driver will be employed to perform _____

Average period of time the driver will be driving each day while on duty: _____

Number of years experience driving all types of motor vehicles: _____

Transmission type (auto or manual – if manual; designate number of forward speeds): _____

_____

Steering – manual or power assisted:_____

Description of any vehicle modification(s) made for the driver-applicant (attach photograph(s) where applicable): _____

Seating capacity of passenger carrying vehicles:_____

The co-applicant employer/motor carrier must certify that the driver-applicant is otherwise qualified under the regulations of 49 CFR 391, Qualifications of Drivers:

THIS IS A NEW HAMPSHIRE **ONLY** MEDICAL WAIVER

_____ _____/____/_____

Driver –applicant's Signature Date

By signing above, I certify that this application is signed under penalty of unsworn falsification pursuant to RSA 641:3.

IF APPLICABLE:

_____

PRINT NAME

EMPLOYER/MOTOR CARRIER OFFICIAL'S SIGNATURE

_____

(Corporate Officer, partner or proprietor)

____/____/____

Date

By signing above, I certify that this application is signed under penalty of unsworn falsification pursuant to RSA 641:3.

GRANTING OR DENIAL OF WAIVER

The application shall be reviewed by the Director of the Division of Motor Vehicles and submitted to the Assistant Commissioner of Safety with a recommendation to grant or deny a waiver. Final determination shall be made by the Commissioner and the applicant shall be notified in writing by the Commissioner. Approvals shall include terms, conditions, limitations, and additional information deemed pertinent by the Commissioner.

If an applicant is denied, the applicant may petition the bureau of Hearings and request a REVIEW OF THE APPLICATION AND SUBSEQUENT DENIAL. Such a request must be submitted in writing with the petitioner's name, address, and date of birth to:

DEPARTMENT OF SAFETY
DIVISION OF MOTOR VEHICLESSTEVEN E. MERRILL BUILDING
23 HAZEN DRIVE
CONCORD, NEW HAMPSHIRE 03305

EMPLOYMENT HISTORY

EXPERIENCE AND QUALIFICATIONS - DRIVER

Drivers Licenses: License #: Type: Exp date:

_____ _____ _____ _____
State

Drivers Licenses: License #: Type: Exp date:

_____ _____ _____ _____
State

Drivers Licenses: License #: Type: Exp date:

_____ _____ _____ _____
State

Driving Experience:

Class of Equipment: Dates from To Approx # Miles

Straight Truck ☐ _____ _____

Tractor and Semi Trailer ☐ _____ _____

Tractor-Two Trailers ☐ _____ _____

Other _____

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED):

DATES: NATURE OF ACCIDENT (Head-on, Rear-end, Upset, Etc) FATALITIES INJURIES

Last accident: _____/ _____/ _____

Next Previous: _____/ _____/ _____

Next Previous: _____/ _____/ _____

TRAFFIC CONVICTIONS and FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS):

LOCATION: DATE: CHARGE: PENALTY:
_____ ____/___/____ _____ _____
LOCATION: DATE: CHARGE: PENALTY:
_____ ____/___/____ _____ _____
LOCATION: DATE: CHARGE: PENALTY:
_____ ____/___/____ _____ _____

(ATTACH SHEET IF MORE SPACE NEEDED)

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? Yes _____ No _____

B. Has any license, permit or privilege ever been suspended or revoked? Yes _____ NO_____
If the answer to either A or B is yes Attach statement giving details:

EMPLOYMENT RECORD (attach sheet if more space is needed)

Note: DOT Requires that Employment for at Least 3 Years and/or Commercial Driving Experience for the past 10 Years be shown

LAST EMPLOYER:

NAME: _____

ADDRESS: _____

POSITION HELD:_____ FROM: _____ TO: _____SALARY: _____

REASON FOR LEAVING: _____

SECOND LAST EMPLOYER:

NAME: _____

ADDRESS: _____

POSITION HELD:_____ FROM: _____ TO: _____SALARY: _____

REASON FOR LEAVING: _____

THIRD LAST EMPLOYER:

NAME: _____

ADDRESS: _____

POSITION HELD:_____ FROM: _____ TO: _____SALARY: _____

REASON FOR LEAVING: _____

TO BE READ AND SIGNED BY APPLICANT

This certifies that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge.

_____ _____

DATE APPLICANT'S SIGNATURE

By signing above, I certify that this application is signed under penalty of unsworn falsification pursuant to RSA 641:3.

NOTE: A motor carrier may require an applicant to provide information in addition to the information required by the Federal Motor Carrier Safety Regulations .

MEDICAL EVALUATION SUMMARY

(to accompany application for waiver of physical deficiency)

The medical evaluation summary must be completed by a licensed physician. The driver-applicant shall provide the physician with a description of the job task he will be required to perform.

TO THE PHYSICIAN:

As more particularly described in Saf-C 909.07, the summary shall include one or more of the following: an assessment of the driver's functional capabilities as they relate to their ability to perform normal tasks associated with operating a commercial motor vehicle; an explanation as to how and why the impairment interfered with the driver's ability to perform normal tasks associated with operating a commercial motor vehicle; the description of any prosthetic device from a medical examiner or specialist; the recommended time period of the waiver; and an assessment of whether the condition will likely remain medically stable over the driver-applicant's lifetime.

Please print or type.

Applicants Name:_____ DOB: / /

Please use the space below for your medical evaluation summary

/ /

Signature of Physician Date

By signing above, I certify that this application is signed under penalty of unsworn falsification pursuant to RSA 641:3.

Name of Physician: _____

Name of Practice: _____

Address: _____

Telephone #: _____